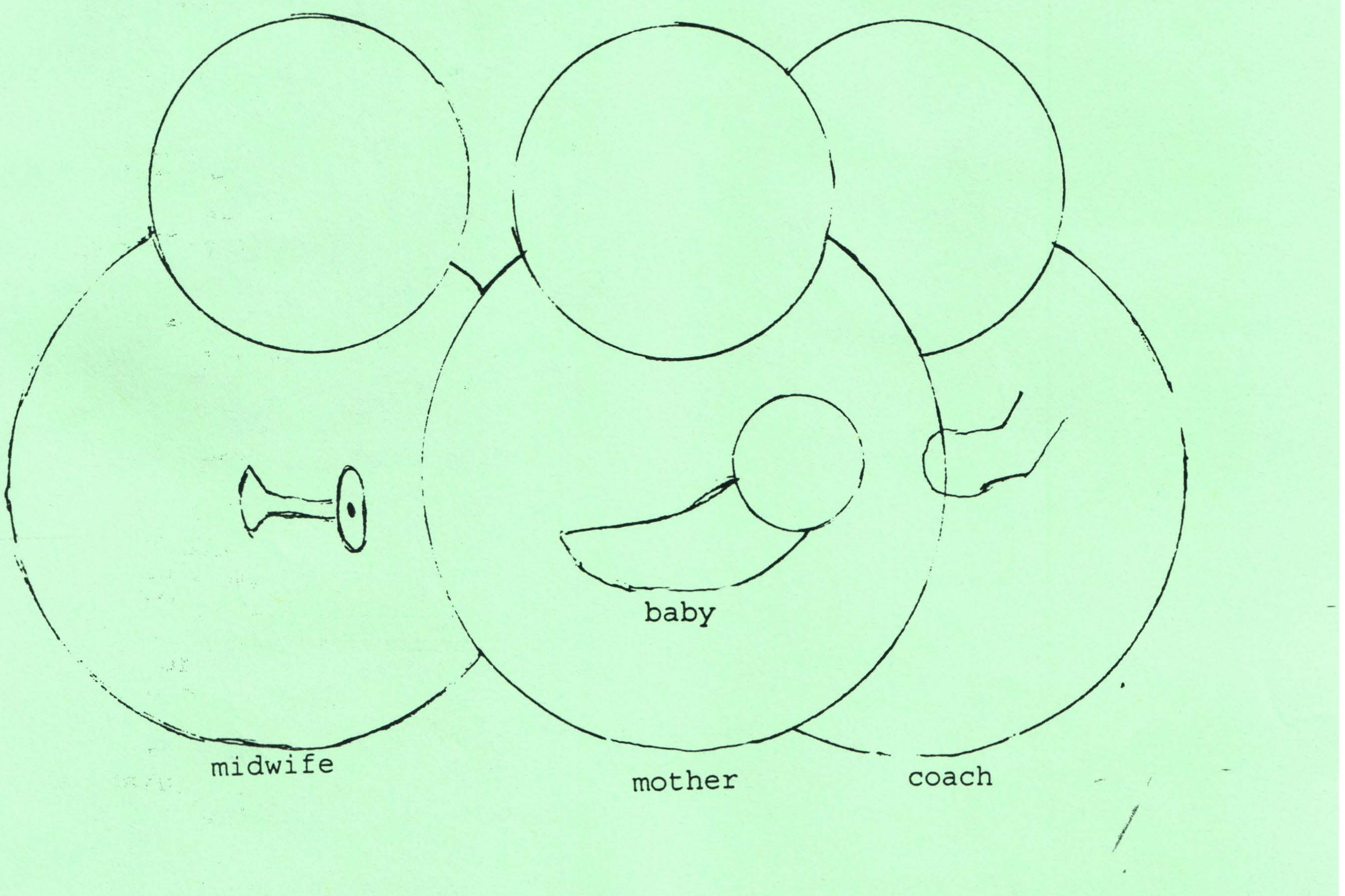
NEWFOUNDLAND & LABRADOR MIDWIVES ASSOCIATION



Newsletter No. 10, June 1999

During the "Midwives Today" Conference, St. John's, 1994
Lobster Supper at Sharon Ransom's House

Standing (left to right): Sandra Botting*, Alison Rice, Ruth Graham, Karen Olsson, Eleanor Nolan, Sharon Ransom, Pearl Herbert
Sitting (front to back):Eileen MacKenzie, Cathy Ellis, Betty-Ann Daviss, Margaret Moise, ?

*Sandra Botting (Alberta) was strongly dedicated to midwifery. We are sad to announce that she died on Mother's Day, May 9, 1999.

Just Received June 28, 1999.
Measuring up: A health surveillance update on Canadian children and youth. A report from the Laboratory Centre for Disease Control (LCDC), Health Canada, which "brings together the most recent child health surveillance information from various bureaux within LCDC". "The report contains selected indicators of infant health, childhood cancer, vaccine-preventable diseases, respiratory health, child injury, and HIV and sexual health".
This report consists of 59 pages, Cat.No. H42-2/82-1999E
Available from web site: http://www.hc-sc.gc.ca/hpb/lcdc
May be obtained by mail from:
Bureau of Reproductive and Child Health, Health Canada, LCDC Building #6, Tunney's Pasture, Address Locator 0601EZ, Ottawa, ON, K1A 0L2

Newfoundland and Labrador Midwives Association
(Chapters in Goose Bay and St. John's)
Newsletter 10
June 1999
(International Year of the Older Person)

This Newsletter contains information from the annual general meeting of the Canadian Confederation of Midwives/Confederation Canadienne des Sages-Femmes (CCM/CCSF) which was held in Montreal on June 5 and 6, 1999. Also a report from the Fetal Alcohol Syndrome Forum held in Ottawa on May 25, 1999, and the last committee meeting of the CPSS.

It seems that there is very little interest from members about submitting information regarding themselves for the Newsletter. Therefore, the one note which I did receive I have not included. Thank you to those who did provide contributions.

Items for the Newsletter are welcomed and those who submit are responsible for obtaining permission to publish in our Newsletter. The Editor does not accept this responsibility.

Pearl Herbert, Editor, c/o School of Nursing,
Memorial University of Newfoundland, St. John's, NF, A1B 3V6 (Fax: 709-737-7037)

General Meeting of the NLMA will be held by teleconference, August 27, 1999, at 4 pm (island time). In Studio 3, HSC, for those in St. John's Elsewhere, please make your usual arrangements. New Members Welcomed, interested midwives, "wannabees", professionals interested in maternity care

Is this your last Newsletter?
1999 Membership Fees are Due, Membership Form at the End of the Newsletter

Perinatal Nursing CNA Certification Examination March 25, 2000
Applications for the Examination to be submitted by November 5, 1999
Information from the Canadian Nurses Association, telephone 1-800-450-5206

August 1-7, 1999, World Breastfeeding Week
Breastfeeding: Education for Life

Executive Committee

President:	Pearl Herbert	Secretary:	Karene Tweedie
Treasurer:	Pamela Browne	Co-Signer:	Alison Craggs

Newsletter Editor: Pearl Herbert
Home page: http://www.ucs.mun.ca/~pherbert/ Newsletter in HSLibrary: WQ 160 N457n

Annual General Meeting of the CCM/CCSF, June 5 to 6, 1999

This meeting was held in Montreal. I arrived at lunch time on Friday, June 4th, at the end of the RSFQ annual meeting and listened to an aboriginal midwife from Ontario speak about midwifery practice in her community. Then in the evening there was a public meeting in downtown Montreal at the l'Institut de Touisme et d'Hotellerie du Quebec. This was so that we could let people know about midwifery in other provinces. I also had the opportunity of meeting midwives who had been in this province whom members may remember, including Jenny Stonier, Fran Wertman.

On Saturday and Sunday we met at the Birth Centre in Pointe Claire. Fortunately no women in labour arrived, but it is quite large. The Centre is the whole of the top floor of the CLCS Lac St.Louis so that when any women need to visit health or social services personnel they are all in the same building. The Birth Centre has an entrance hall where a receptionist works. Then along one corridor are three nicely decorated birthing rooms with private bathrooms. There is also a TV lounge and large kitchen/dining area. A patio door leads to a fenced off roof area where the children can play and the woman can sit in a reclining patio chair. At the end of the corridor was the pine wood coloured emergency trolley which is placed outside of the room when a woman is giving birth. Along another corridor are three offices with examining tables for the midwives. There are also large storage cupboards. Off the reception area is a meeting room where classes are held, and a small kitchen area. This meeting room is where we met. The midwives had provided food for the breaks, and for lunch which we ate in the large dining area along the corridor. On the Saturday evening we were invited to a pot-luck supper provided by the midwives at one of their homes.

1. At the meeting were representatives from British Columbia, Alberta, Saskatchewan, Manitoba, Ontario plus an observer, Quebec from both the RSFQ and AQSF, Nova Scotia, and Newfoundland and Labrador.
2. The Byelaws for the Midwives Association of Manitoba (MAM) were accepted as sufficient for incorporation in Manitoba and so accepted by the CCM/CCSF. Apparently in that province they do not require a Constitution. Every province/territory has different laws, including those for health and for education. MAM now replaces the two other midwives groups in that province. (The Midwives Associations usually have to reorganize when legislation is passed).
3. A letter dated Spring 1999, from the Midwives Alliance of North America (MANA) was handed to those present, by one of the representatives. It had not been given to the CCM/CCSF Coordinator prior to the meeting. This letter resulted in much discussion. Extracts from it are:

"At the MANA Spring Board meeting (April 1999), during our strategic planning session, the Board agreed that the time has come for a clear identity to emerge . . . and it is the intention of the Board to change the structure of MANA by redefining it as an US organization. . . Differences in the politics and health care systems between the US, Canada, and Mexico were named as obstacles to creating a truly North American organization along with the fact that the Canadian midwifery movement no longer seemed to need or want MANA's support and input. . . MANA-Mexico will continue as it is but may in the future decide to fly more on its own. For now, the support financially and otherwise is critical to the Mexican midwifery movement. An International Liaison Day at both Board meetings and the annual conference are being proposed where both the MANA-Mexico and Canadian representatives would be invited to attend and participate".

Discussion also included the fact that in the past the CCM has passed resolutions stating that there would be no MANA observer at CCM meetings, so it was inappropriate for a MANA Board member to also be a CCM/CCSF representative for a provincial Midwives Association. Anyone can join MANA but membership in the CCM/CCSF is through being a member of the provincial/territorial Midwives Associations. Once legislation is implemented this is the Association which represents the licensed/registered midwives in a province/territory.

In Canada the ideal education preparation for a beginning midwife is at the baccalaureate degree level. Provinces often insist that new midwives have successfully completed programs at the degree level which include classes in women's studies, biology, human science, research, during the past 10 years. Midwives need to be able to compete for recognition with other professionals, otherwise midwifery will remain a marginal profession.

4. Those who had attended the International Confederation of Midwives Congress gave a brief summary of the meetings. The next Congress is April 14-18, 2002, in Vienna, Austria. In 2005 it will be in Brisbane, Australia. The executive meeting in 2001 will be held in Zimbabwe. The Vienna Congress will be the first time that euro money will be used. The Canadian Associations who currently have representation at the ICM are MABC, AOM, AAM, AQSF. The Americas were under represented; Peru has had regulated midwifery since 1896. On the agenda was the "Role of the Midwife", and the core competencies required. The ICM and the South East Regional Office of the World Health Organization (SEROW) are working on midwifery standards. This is closely related to the Safe Motherhood project. The ICM office is moving to the Hague.

Discussion regarding CCM/CCSF pursuing the possibility of becoming an ICM member.

5. The membership of the CCM/CCSF was also discussed. That there should be an executive, plus representatives from the provinces/territories. Once legislation is passed membership of Midwives Associations are: full members (registered midwives), retired midwives, student midwives, midwives on leave of absence (maternity leave etc.). An executive consists of the president, secretary, treasurer. At present the CCM/CCSF has a coordinator and treasurer.

Those who are representing Midwives Associations should be a member of that Association's executive, be able to speak for their Association and know the Association well. They should also have electronic mail.

6. The Treasurer, Fran Wertman, gave her report. The membership fees for the current year, are $7 per midwife. The approximate number of midwives are: BC=75; AB=18; SK=2; MB=9; ON=150; PQ=70; NS=10; NF=10; PE=2 (There are no Associations in NB, NWT, YK). When legislation comes into effect the numbers decrease because not all midwives decide to pursue licensure/registration.

7. The vision for the next year for the CCM/CCSF involves obtaining a permanent postal address. In two years to have a new Constitution and Bylaws in effect, to arrange a national conference. In three years to have the ICM membership completed, and a national midwifery examination. To have a web site for a home page and to correspond by e-mail, including the sending of agenda items and Association reports.

8. There was a minute of silence to remember Sandra Botting, who was diagnosed with cancer in February 1999, and died on Mother's Day. She was a mother and a midwife. She had been very active in midwifery, belonging to the Alberta association, MANA, and was a founding

member of the National Association of Parents and Professionals for Safe Alternatives for Childbirth (NAPSAC). Sandra represented Alberta at our 1994 "Midwives Today" conference in St. John's.

9. Reports from the those who represent CCM/CCSF on other committees:

Breastfeeding Committee for Canada. The last meeting was in November and was reported in the January 1999 Newsletter. A new publication is: Health Canada. (1999).
Breastfeeding in Canada. A Review and Update (ISBN: 0-662-27047-9) 88 pages.
Available from Publications, Health Canada, Ottawa, ON, K1A 0K9. (Fax: 613-941-5366).
It is also on the internet at: http://www.hc-sc.gc.cs
Pearl Herbert has finished her term (5 years). There is unlikely to be funding for committee members to attend future meetings.

Fetal Health Surveillance Steering Committee (Pearl Herbert) and the Fetal Health Surveillance Curriculum Committee (Eileen Hutton). These committees were set-up following the SOGC's guidelines for Fetal Health Surveillance as written in the *Journal of the SOGC, 17*(9), 859-903. In a letter dated June 9, 1999, from Pat Niday, co-chair, she apologized for the communication gaps that have occurred with this project. Producing eight drafts of a large document has been costly, so only draft 6 was circulated for feedback. This was funded by a one-time contribution from SOGC. There are various options of how the final document could be distributed, including on a CD-ROM In order to find funding to advance this project (meaning development of the educational curriculum for a course to accompany the self-learning manual, and a course for instructors), letters of support are needed. The letters should state why a self-learning manual and courses are needed, and sent to Patricia Niday, RN, PhD, Executive Director, Perinatal Partnership Program of Eastern & Southeastern Ontario, 401 Smyth Road, Ottawa, ON, K1H 8L1 (Fax: 613-738-3633).

Neonatal Resuscitation Program. As there is no funding available for travel to these meetings the CCM/CCSF representative is from the city where the meeting is to be held. This year the meeting was June 21st in Winnipeg, so a member of the MAM was attending. Also, see the article:
Kattwinkel et al. (1999). An advisory statement from the Pediatric Working Group of the International Liaison Committee on Resuscitation. ***Pediatrics, 103***(4), 56.
Can also be obtained from http://www.pediatrics.org click publications on the left side of the screen and find Pediatrics and click on the volume number and the issue number.

Canadian Coalition for the Prevention of Developmental Disabilities (Betty-Anne Daviss). There was nothing new to report.

Consensus Conference on Infected Health Care Workers: Risk for Transmission of Blood borne Pathogens Nothing new.

Revision of the Family Centred Maternity and Newborn Care National Guidelines (Charlene MacLellan). There was nothing new to report regarding the revision of these guidelines.

College of Family Physicians of Canada (Karen Kaufman). No report received.

The SOGC's Task Force Advisory Group on Women's Health does not have a representative from Canadian midwives. There is a midwife from Ontario on the committee but apparently she just represents herself.

Canadian Perinatal Surveillance System Steering Group (Pearl Herbert). A meeting was held in Ottawa on April 13, 1999.

On Monday afternoon, April 12th, prior to the main Steering Committee meeting, there was a sub-committee meeting of the group involved with "Women's Behavior in Pregnancy". When we had first met in November we had not fully agreed with the objectives. We are now planning a survey to include the behaviors, knowledge, attitudes and perceptions of women from pregnancy through to the first year of parenting. There is also the suggestion that we include a survey of care providers. We are now searching for studies which have been carried out on women's perceptions, and the one by Penny Simkin has been suggested. If you know of any studies which have been carried out about behaviors and/or knowledge, and/or attitudes, please let me know before June 1999.

On Tuesday the CPSS Steering Committee met for a whole day (0830 to 1630). The various subcommittees reported on their activities including publications:
The Fetal and Infant Mortality group reported more linkages between Statistics Canada files. There is still a need for the analysis of existing Statistics Canada data. Also, to endeavour to have key variables added so that the number of indicators CPSS can report nationally will be increased. They are proposing a series of ultrasound examinations on all babies to determine fetal health curves. Those which are in use now were developed many years ago.
The Maternal Morbidity and Mortality group reported that during the past 5 years there were 99 maternal deaths. The number of hospitals providing obstetrical services (about 450) has nearly halved in the past few years. The CIHI 665 category is confusing as the codes are similar for cesarean births, ruptured uterus etc. The CIHI representative to the CPSS is going to examine this category, as at present some of the data are questionable.
The Abortions and Anomalies group reported that they are finding a gap between early detections and terminations of pregnancies and those which continue to viability. The use of computers in abortion clinics varies from province to province, depending on the provincial reporting requirements, computer skills of the workers, etc. This is on the agenda of an annual meeting at the end of the month.

Statistics Canada is developing a new survey to be started within about 12 months.

The representatives from various national organizations who are members of this Steering Committee gave their reports, so that there could be a clearer understanding of what the stakeholders expect from the CPSS, and how these organizations relate to the CPSS. Many organizations have a form which the person representing them on any committee completes, and attaches copies of any handouts. These reports go to the Board members but only a few organizations circulate copies to their membership. I could only comment on what the Newfoundland and Labrador Midwives Association does regarding these reports as I do not know how other Midwives Association share this information. The Ontario Midwives are required to provide data for the provincial government and so have devised their own data

collection form. Midwives in BC complete their government's data form. Other midwives may complete the Canadian Midwives Statistics Collaboration (CMSC) form from which the data are easily retrievable for Canada. A new member was from **ACE** which represents epidemiology experts in the provinces who concentrate on chronic and communicable diseases. They look at health rather than services and have links with all provincial/territorial surveillance systems. **CIHI** maintains Canada's Health Information System. The CIHI is incorporated but is not governmental, although government personnel sit on the Board to ensure that there are no duplications of services. The CIHI has contracts with provinces. The aim is to standardize one common core and so prevent many groups collecting data from the same source. The document *Health Information Needs in Canada* was followed by *Health Information Road Map*. The information proposed for this Road Map is to be received by September 1, 1999, so that the structure may be completed this year. As already stated above, there are some queries about the data collected and so this has to be investigated prior to its use by the CPSS. The **SOGC** finds that many of its members do not understand the complexities of developing the Surveillance System nor know about the unreliability of some of the available data records. For example, the Ontario figures are not being used following the findings of truncated birthweights which were reported in the September 1, 1997, *Canadian Medical Association Journal*. (This year both the SOGC and the CPS annual meetings are being held June 25-29, 1999). **CPS** members who are neonatologists are aware of the CPSS but other members are probably unaware of its existence. The **CICH** is the only group which represents both professional and consumer members.

Other information included that the *Resource/Reference Manual for Definitions, Uses and Interpretations of Key Indicators* will soon be ready and it is planned that it will be distributed to a small subset of potential data suppliers, at the same time as either a progress report or the annual report is mailed.

<u>Fetal Alcohol Syndrome Forum (May 25, 1999)</u> (Pearl Herbert)

The Forum was held at the Government Conference Centre in Ottawa. A welcome was given by the Honorable **Ethel Blondin-Andrews**, Federal Minister for Youth and Children. **Lorraine Greaves**, Director of BC Centre of Excellence for Women's Health, spoke about women's centred care which involves women in health care planning and participation in decision making. There is a need for women to be empowered. Often intervention programs do not last as the motivation is lost, but the key to lasting programs is social determinants. There are about 60% of pregnancies in which problems occur. Violence may occur in pregnancy resulting in a low birth weight baby. Prenatal care can have an effect on the mother's use of alcohol. Women may face barriers trying to access treatment due to a lack of information on how to obtain help, a fear of treatment, and long waiting lists for treatment. They may have feelings of depression and low self esteem. Children and health problems are strong motivators as to why a mother may seek help, and these are assisted by supporting professionals, family members, friends. There are similarities between women seeking help for alcohol problems and those wanting to stop the use of tobacco. A program needs holistic concepts, to provide safety in treatment, and the removal of barriers to accessing treatment. (Similar to the findings in Boyd, S. (1999). *Mothers and Illicit Drugs*).

Dr. Sterling Clarren, Medical Director. Washington State Fetal Alcohol Syndrome (FAS) Diagnostic and Prevention Network, spoke about his model that has spread to five States. A syndrome should never be named after an object, but FAS was named as a prevention term. FAS is about the mother and not the child, but physicians do not want to label the child, so do not make a diagnosis, but they fail to relate the problem to the mother. All professionals need to work together to deal with the problem, and they need to take it to the government. In the State of Washington interested people came together, and instead of asking for money for a project, requested that communities should be made aware of the problem. Now there is somewhere for people with a problem to go, and so it has become ethical to diagnose the problem.

Dose and timing of drug-taking during pregnancy are important but with alcohol there is no dose that is relative. Never a 100% risk but a 50% risk. The only known fact is that: no exposure results in no risk. With identical twins the results are equal but with fraternal twins there are different effects, and one twin may be affected whilst the other twin is not affected. High levels of alcohol intake occur in about 3%-5% of pregnancies. There are only a few good studies regarding this. FAS accounts for 50% of children who are retarded. Unlike cigarette smoking where one cigarette results in addiction 99% of the time, there is no evidence that one glass of wine is harmful or addictive. Smoking is dangerous to the woman's health and to the health of others. Smoking also becomes annoying to others and so they complain.

In one study, 50% of FAS children were living with their mother, 50% were fostered. Of the latter, 25% of the mothers were dead, and 25% could not be found mainly because of breaking confidentiality of information. The mothers may have tried to stop drinking before the child was born but were unsuccessful. Of 1,000 women interviewed, only 50% had alcohol mentioned in their medical records. Their IQs were similar to the population and some women had a very high IQ. A 100% of the women had suffered severe abuse, physical or sexual, much of which had occurred during childhood but had never been resolved, 85% had psychiatric problems including phobias about leaving the house, 25% had organic brain dysfunction related to alcohol, and 25% were afraid that they would be abandoned by partners and friends if they did not drink. Alcohol was a partial solution to their problem, and if removed a replacement would be needed. The women chose birth control over having a baby, and depo-provera was the main choice. It is a long term choice and cannot be reversed by their partner. For 80 women there were 272 children, 51 born after the previous baby had been removed from their care, 6 babies had FAS, 75% had been exposed to alcohol, and 80% of the women had not been offered birth control.

Women with schizophrenia and other organic brain damage do not store nor interpret information the same as other women. They deny that alcohol will affect the baby. Educational posters about FAS do not show the role of the father and the community when the mother is drinking alcohol. Molson Brewery's latest poster only shows a fetus and the words "She drinks what you drink". Nothing about the effects of alcohol.

Dr. Clarren then spoke about a program which has been developed to diagnose FAS. When FAS is being diagnosed, the three parameters studied are the facial features, growth deficiency, fetal anomalies. There is a four-point scale on which growth, face, brain, alcohol, are charted, 1 is slight and 4 is gross (FAS is the highest). 4 and 3 encephalopathy, 2 family gives a report but not found by tests so further considerations are needed, 1 is normal. Then, 4 exposed

to alcohol, 3 probably exposed, 2 exposure unknown but the child fits the description, and 1 not exposed. However, growth is problematic as the child may be malnourished, have short of stature parents, have a combination of a short, slight build, low head circumference and hence be scrawny. So need to weigh and measure, and exclude malnourishment and disease. There is a book which describes how to adjust for these. To make this easier a computer program has been developed. The epicanthal folds and the size of the eyeball (formed from early brain tissue) can be measured. A small eyeball shows a small brain organ. When formed, the facial bone grows downward and forward. On the 19th and 20th day of gestation there is no face, only brain tissue, so if affected on that day then the nose is short.

Everybody can have their picture taken (when not smiling as this distorts the face) so it is easy to make an assessment. The photograph is scanned into the program and then measured accurately instead of having to "eyeball" the face. By the end of the summer a CD ROM will be ready to be sold by the March of Dimes. It is not known if there are differences between aboriginal, black and Caucasian measurements. People have a three-day workshop of training in the use of this method: day 1 is a general introduction, day 2 to observe the procedure, day 3 discussion. Then they have their own patients but each patient is discussed with the mentor before they are seen, afterwards they analyze the findings together. After 18 months they are confident to practice on their own. There are also free one day workshops.

At present FAS is not considered a medical problem, but if a lesion of the brain can be shown, with major structures missing, fewer white cells, fewer neurons which cannot move to a correct position, then this view can be changed. Magnetic Resonance Imaging (MRI) is a powerful tool which is able to do this, and is cheaper than individual multiple tests.

The FAS child has concrete thinking (being told not to run <u>in</u> the street is not considered to mean the same as running <u>across</u> the street). To deal with a child with FAS a multi-disciplinary team is needed. Experts for speech and language, psychologists, experts to interpret findings etc. There are also mechanized dolls which have a non-consolable cry (until the battery is removed) to demonstrate the frustration of caring for a baby with FAS. For further information regarding the Washington program, and articles, see the web site
http://depts.washington.edu/fasdpn

Dawn Ridd of the Manitoba Youth and Children Secretariat spoke on how children at risk are followed up to 3 years of age, but they are now considering extending this until young adulthood. There are 240 children with FAS born in Manitoba every year, and this costs $1 ½ million per child per lifetime. It was seen in Seattle that when women had access to treatment and birth control, they were able to regain custody of their own children. The Stop FAS program was started in Manitoba in 1998. So far, two sites have been set-up in Winnipeg and one each in Norway House and Thompson. A program coordinator oversees mentors who are the front line staff working with the women. The aim is to work with mothers of FAS children and prevent further FAS children from being born. The women may need other types of counselling, such as for physical or sexual abuse. They have often been expelled from school, their family, and various other services, but they do not get expelled from the FAS program. To enter the program the women must either be pregnant or no more than 2 months postpartum, and aged 19 or over. The mentor and the woman discuss what each expects of the other. There is a card game "It Would Make a Difference in My Life" to help the discussion. They end up with five goals and organize these into priorities. Then they are visited every 4 months to see if the goals have

changed. As time progresses the woman has to move from dependency to interdependency. The mentors are chosen because of their own life experiences which they can bring to the situation, and their belief that all women love their children. The goals of the program are to provide someone for the woman to talk to, to be able to obtain treatment so that she can have access to her children, and then to obtain custody of her children. As it costs $1,000 pa for foster care and $1 ½ million for a life time of care for a child with FAS, there is soon sufficient money saved with which to cover the mentor's salary.

Manitoba is now working on guidelines for the program, including ***midwifery care***. Saskatchewan is in the process of making video tapes for training professionals and mentors for the program. Aboriginal groups have many ideas but need a facilitator. The aboriginal groups are applying for permission to translate the resources into their own languages. More information may be obtained from Dawn Ridd, Youth and Children Secretariat, 100-233, Portage Avenue, Winnipeg, MB, R3B 2A7 (Fax: 204-948-2585). Contact this address for information about a conference May 11-13, 2000. 200 Manitoba: Prairie Province Conference on FAS at the University of Manitoba, Winnipeg. Abstracts by August 1, 1999.

Della Maguire, of the Nova Scotia Micmac Native Friendship Centre, told how they have a manual. They recently had a workshop where people kept a journal and then the next day reviewed the previous days events and raised questions. This provided a safe place to learn. For more information contact Della Maguire at RR1, Hantsport, NS, B0P1P0 (Fax: 902-423-6130)

Tracy Butler and **Margaret Leslie** spoke about Breaking the Cycle (BTC) an Ontario collaborative community based program. Services are often fragmented for women who are addicted. Existing services need to be reorganized and made more accessible. To be in this program women must be parenting a child less than 6 years or be pregnant, and must be addicted. The steering committee partners meet monthly, and agencies meet two weekly to review clients. The women have requested to meet in a home-like environment, transportation to and from the service and a hot meal. Breakfast and dinner are provided for the children. Increased mental health support is provided as many of the women have been abused. A physician provides a family practice medical service and has a methadone license. The women develop strong attachments with the staff and with each other, and stay in the program for many years. The program evaluation shows that the BTC is meeting its primary objective of improving the well-being of children of mothers with substance use problems. The women were aged between 16 and 45 years, average 28.8 years, 25% did not have a permanent residence, 63.7% single parents, 26.3% on probation and parole, 30% waiting for a court case. They had an average of 4 pregnancies, 60% of children in the care of their mother, 3% in the care of the father, 60% had been separated from their parents. The children had language delays, attention problems and behavioral problems. Copies of *Breaking the Cycle Evaluation Report*, 1995-1997, are available from Breaking the Cycle, 63 Lombard Street, Toronto, ON, M5C 1M2 (Telephone: 416-364-7373. Fax: 416-364-8008)

Other: Canadian Centre on Substance Abuse Clearing House, web site: http://www.ccsa.ca
FAS Link web site: http://www.acbr.com/fas/faslink.htm
Canadian Perinatal Surveillance System fact sheet, *Alcohol and Pregnancy*
web site: http://www.hc-sc.gc.ca/hpb/lcdc/brch/reprod.html

Graefe, S. (1998). *Parenting children affected by FAS. A guide for daily living* (2nd ed.). Ottawa: Adoption Council of Canada, 180 Argyle Avenue, #329, Ottawa: ON, K2P 1B7 ($10.00 each). Telephone: 1-888-54-ADOPT Available in French.

Precious Gift (video, 16 min). Filmed on the Beardy's and Okemasis Reserve in Saskatchewan. Available from: Saskatchewan Institute on Preventing Handicaps, 1319 Colony Street. Saskatoon, SK, S7N 2Z1 ($15.00). Fax: 306-655-2511.
There is a section on FAS on the web site: http://www.usask.ca/medicine/prevent

International FAS Day, September 9. Remember this on 9/9/99 at 9.09. For more information Fax: 416-264-8222. Web Site: http://www.come-over.to/FASWORLD/

Midwifery News, June 1999

British Columbia. Midwives have been regulated in BC since January 1998. The model of midwifery is that midwives are community based, practising as autonomous primary care providers. They provide evidence-based care. They provide women centred care within a partnership with clients and provide informed choice. They offer women choice of birth place and provide continuity of care by working in small teams. They work in partnership with other health care providers, and most have hospital privileges although in some areas there has been physician opposition. These privileges have been easier to obtain where midwives had already established effective working relationships. As of May 1999 there are 49 Registered Midwives practising in BC, mostly in small groups with a couple in solo practices where they are the only midwife living in a community. There are too many midwives in the Fort Nelson area, a scarcity in the central area, and too few in the south of the province where they have to turn women away. Most of the registered midwives went through the assessment process in 1997 achieving eligibility to register in 1998. A few became registered through the College of Midwives of BC's (CMBC) reciprocity policy where midwives who have been assessed for registration in other provinces, and who can move to an area where there is a need to provide supervision for Conditional Registrants in BC. A second intake process is currently underway. This process is intended to provide a mechanism for qualified, practising midwives to become registered. After the portfolio assessment component approximately 50 applicants are likely to go on to the next stage of the assessment process and take the written examination at the end of June. The clinical skills assessment will be in October, followed by an orientation program. Midwives from the second intake will be ready to be registered by January 2000. It is anticipated that many will have conditions to fulfill to complete the registration process, which will take several months.

Midwifery is publicly funded. The amount for a course of care is $2,250, this includes the payment for a second attendant, which is paid to the Midwifery Practice. The maximum one midwife can bill is for 40 courses of care a year, a total of $90,000. The actual midwives salary is based on that paid to community health nurses. The second attendant policy in BC does not require two midwives to attend at hospital births where this is fulfilled by registered nurses. If there is no midwife to attend as second attendant at a home birth other qualified persons can be approved by the College in which case they are paid by the Midwifery Practice or the individual midwife. Expenses include $4,900 for liability insurance, $1,000 for the MABC and $1,000 for the CMBC, to be paid by each midwife, plus the setting up of an office and the running of a Midwifery Practice.

The Ministry of Advanced Education has been conducting a feasibility study as it is desired that midwifery education should be a baccalaureate program at a recognized degree granting institution. The CMBC has a website (http://www.cmbc.bc.ca/) which contains all the BC regulations and College policy documents. It contains links to provincial legislation including the Health Professions Act under which midwifery is designated and regulated.

The MABC is participating in the BC Centre of Excellence in Women's Health (BCCEWH) midwifery policy research projects. One study has been completed on the Home Birth Demonstration Project tour (although the actual project, which is not about safety but how home births fit into the health system, continues until the end of 1999). The first phase of a study of Nurses Knowledge and Attitudes of Midwifery has been completed. Also in process is an Economic Analysis of Midwifery - Pilot Phase, and a study of the Registration Process. The BCCEWH has also produced a policy paper on midwifery.

The MABC Newsletter is on hold due to the retirement of the previous editor.

Alberta. On July 19, 1998, the Midwifery Register opened and 24 midwives were registered, 10 of whom had restrictions on their registration. In 1994 the Ministry of Health identified $800,000 to be used as an interim funding source for midwifery once regulations were in effect. However, the Regional Health Authorities (RHA) divided this up and gave $200,000 to the Alberta Association of Midwives (AAM) to cover the extra-ordinary costs of regulation; to pay for liability insurance premiums for one year. The RHAs did not want it to appear as though public funds were subsidizing professional liability insurance, although the Alberta physicians have their liability insurance subsidized by the Ministry of Health. The RHAs have hired two midwifery implementation coordinators for one year, one in the north and one in the south of the province. There was $200,000 designated for these two coordinators and it is not known what will be done with the money not used for their positions and salaries.

Women have to pay for midwifery care. The government is planning to carry out a project to "study" 150 midwife attended births - 50 in Calgary, 50 in Edmonton, and 50 elsewhere. If they take part, the women will have their fee refunded. The women have to be registered by 20 weeks gestation and the births have to occur in a hospital. But, the midwives do not yet have hospital admitting privileges because the Minister of Health will not sign the new Hospitals Act and Regulations (prepared two years ago). There is no arrangement for consultations with paediatricians. This project will not create money for midwives and if the women are not selected to be in the project they might drop-out of the midwife's practice resulting in loss of fees. The women have to be able to initially pay and so only women of high socio-economic status can afford to have a midwife, and hence will be studied.

The Premier has said that funding for Midwifery service was never requested. The AAM and several consumer groups have provided documentation that midwives had asked for funding, and the conclusions of the government at that time included public funding of midwifery services. A correction of information has been requested but so far none has occurred, and the newspapers have not printed any of the letters from midwives and consumers to correct this information.

There are currently 18 registered midwives in Alberta, 5 have restricted registration. Two midwives are definitely leaving the province. Fourteen applicants are being reviewed and if successful will be registered sometime in the new year, but they all are likely to have supervision requirements. With the new regulated Health Professions Act, and the elimination of the Ministry of Labour, the Midwifery Regulation Committee will move to the Ministry of Health and

Wellness on July 1 (under the same minister but a new registrar (government employee)). With no funding there is no College. Under the Regulated Health Professions Act all professions will have protection of title and scope of practice. At present only "midwife" is a protected title but at least three individuals are calling themselves "birth attendants" and doing home births. With no funding all discussions about midwifery education have been suspended.

Saskatchewan. The Provincial Advisory Committee reported in April 1996. The Implementation Working Group handed the draft Act to the legislative committee at the beginning of 1999. They have worked on the regulatory bylaws which have to accompany any Act. The legislation was approved by Cabinet on April 29, 1999, and on the International Day of the Midwife they were read for a second time in the Legislature and accepted. In answer to questions raised regarding funding the government agreed to reconsider funding. The government has started to pay physicians' liability insurance. The intent is for both hospital and out of hospital births. The second attendant at births to be able to start intravenous infusions (similar to Alberta). The midwives are going through the registration process in other provinces, such as Manitoba (although that midwife may move there depending on funding) and British Columbia.

At present, both the Friends of Midwives and the Midwives Association of Saskatchewan co-edit a Newsletter, but as progress is made toward having legislation implemented it is expected that there will be a need for two Newsletters, one for consumers and the other for midwives.

Manitoba. In May 1994 the formation of a Midwifery Implementation Council was announced, and the first meeting was January 1995. In June 1997 the Midwifery and Consequential Amendments Act was passed. In the Spring of 1998 the government allocated funding for an Assessment and Upgrading Program to be run for five sessions, each consisting of 10 midwives, over the next 2 ½ years. (They have to make a commitment to work in the province). In March 1999 the Midwifery Implementation Council became the Transitional Council of the College of Midwives. On May 5, 1999, the International Day of the Midwife, the government announced that there would be funding for a College of Midwives of Manitoba, midwifery would be a publicly funded profession, and that midwives would be providing services by the end of 1999. The midwives seeking to become registered are: the few who have been practising in the community; aboriginal midwives; nurses, mainly from overseas, who have been working in hospital labour and delivery, or northern nursing stations; others include those who have not been working in either nursing or midwifery since moving to Canada from their countries of origin. Midwives who have English as a second language have to pass the language test from the Workplace Education Dept. The formation of the Midwives Association of Manitoba (MAM) last year has helped to bring together the midwives from differing backgrounds, who often do not know each other, and the Board is working to bring cohesiveness to the organization. Many are new to the model of Canadian midwifery practice.

A proposal for midwifery education is for a collaborative module program to be offered by the University of Manitoba with the community colleges.

Midwives providing full care to 40 clients a year and assistant to 40 other births to receive $55,000 per year. They do not fall under the employment standard's act. In Manitoba there is also an additional payment to those working north of the 53rd parallel. The second attendant can be anyone who has passed the Neonatal Resuscitation Program and the Cardiac Pulmonary Resuscitation Program requirements, and received orientation to midwifery care.

Ontario. There have been registered midwives practising since January 1994. Recently the method of payment to the midwives has been changed. They did not want to be employees of a health authority as this could affect where and when they worked. The new method of payment is based on 12 weeks of care. For example, as long as the woman registers early in pregnancy and receives 12 weeks of care prior to being transferred to an obstetrician (e.g. with PIH), the midwife will receive a payment. If the woman is transferred prior to receiving 12 weeks of care, then there will be no payment to the midwife. If a woman moves from one midwifery practice to another then only one practice will receive payment. If a woman registers late in pregnancy and the midwife does the birth and postpartum care, then there will be 12 weeks for which she will be paid. Each course of care is $575.00. The money goes to the midwifery practices which have to estimate how many courses of care they need per year to pay for their expenses.

Every year about 30 midwives graduate with a baccalaureate degree from the collaborative midwifery degree program offered at three universities (Laurentian, McMaster, Ryerson). Others can complete the rigorous Prior Learning Experience Assessment (PLEA) process which costs $10,000 per applicant. If aboriginal midwives are recognized in their own communities they may continue practising there without entering the education program. The four- year midwifery university degree program is composed of 80% clinical practice. The final three months is a clerkship when the student is responsible for at least 12 women, with a preceptor. After graduation there is a residency time of 12 to 18 months in an established practice. This is not a supervised time, but there is a mentor. Some hospitals require that the resident be accompanied by a licensed midwife. A question has been raised as to whether it is a residency program.

After 5 years it is still found that the public need to be advised that midwifery is fully funded and that midwives have hospital privileges. About 40% of births occur at home and 60% in hospitals. Five years ago the government cancelled the original plan for birth centres.

The AOM was unable to obtain sufficient advertisers to pay for the insert in the May 5th *Globe and Mail* The midwives are too busy to regularly produce a Newsletter.

Quebec. The Bill 4 Pilot Projects were evaluated, and the midwifery care in birthing centres was extended until September 1999. Various committees have been busy working on establishing standards, a code of ethics, the field of practice, the establishment of a professional organisation, education, and setting up standards for home births. Four universities submitted proposals for a baccalaureate program in midwifery. In March it was announced that the University of Quebec at Trois Rivieres had been granted the funding providing they were able to establish a liaison with a medical school for some of the clinical practice. A program similar to that offered at McMaster University, but with some modifications to fit the Quebec population, will commence in September 1999. For the first 16 places there were more than 100 applicants.

Progress has commenced in starting an independent Order (College). The Office des Professions du Quebec (OPQ) proposed that an Order be created especially for midwives, and that start-up funds be provided. Concern has been expressed by others, such as the Order of Nurses (OIIQ), that due to the small number of midwives (72), there will be a lack of expertise available. To overcome this an advisory council of six people will be formed, consisting of one midwife, one nurse, two physicians, one pharmacist and one member of the public.

On May 5, 1999, the International Day of the Midwife, the Minister of Health announced in Parliament that it was time women were able to choose the professional services of a midwife. Subsequently, on May 12 the new law, Bill 28, was finally deposited in the Quebec National Assembly for reading during the current session.

It is proposed that midwives still be funded by the community health centres (CLSC) and that they become more integrated into the community health services. Remuneration and case loads, and standards for home and hospital births, have yet to be negotiated. At present it is estimated that care through the birth centres is $200 less than the standard care provided by physicians in hospitals.

This Spring there was to be another examination for those who wanted to be assessed as being qualified to work in birth centres. The Association des Sages-Femmes had 17 members who were to take this examination but a few days before the examination it was suddenly cancelled by the government. The Association still exists but once legislation comes into effect only the group which represents the registered midwives will be represented on the Canadian Confederation of Midwives (CCM) as stated in the draft constitution.

Nova Scotia. The Interdisciplinary Working Group on Midwifery Regulation, the first official committee appointed to focus on midwifery issues, completed its report in May 1999. There were four midwives on this 22 member committee. The model of midwifery being developed is similar to the models already standardized in other provinces. The two physicians on the committee state that they will only support home birth if certain criteria are met, including transport methods, screening etc. The report is expected to be released the middle of June, when there will be a press conference. The cost of midwifery care is estimated as $5,000 for the full course, but if accommodation (based on hotel rates) is removed this is $3,500.

The Grace Maternity Hospital (IWK-Grace), is moving toward opening a Birth Centre with a target date for July 1999. Fran Wertman (CCM Treasurer, and a graduate of the MUN Midwifery Program) is coordinator of the Birth Centre. This will be for low risk births and the women will know their nurse, who will be the labour support person. Nurses have consulted with the Nurses Union as they will be working outside of the Union's work schedule. (This is similar to how the midwives, who were also nurses, worked at the BC Women's Health Centre (formerly the Grace Hospital) prior to legislation coming into effect in BC in 1998).

Newfoundland and Labrador. The Provincial Advisory Committee on Midwifery submitted their final report in May 1994. One of the recommendations was for an implementation committee to be appointed to consider the model of midwifery for this province. So far nothing has been received in writing In February 1999 we heard a rumour that the Minister of Health was considering an implementation committee. On June 3, it was heard that the chairperson has been formally appointed and that of a 18-member committee the recommended midwifery composition is 50%.

A public awareness and consumer advocacy group, Friends of Midwifery of Newfoundland and Labrador, was formed in June 1994, because of the growing interest in the role of the midwife. The impetuses behind the formation and continuation of the group are women who are dismayed when they discover that they are unable to have midwifery assisted

births, and the continuity of care from early pregnancy through to the end of the postpartum period. The women have experienced midwifery care when living in another province or country, or have heard about midwives through the media, and from friends in other provinces and countries where midwives are practising. Furthermore, in the St. John's health region there are only eight family physicians providing obstetrical care, and three of these are in Shea Heights and only provide care to women in their location. The pregnant women are often transferred to an obstetrician, but obstetricians only work during the day and take it in turns to be on call at night and weekends. On May 1, 1999, this group held a celebration morning in St. John's. They launched their Newsletter and their new name, **the Midwifery Coalition of Newfoundland and Labrador**. For information about the Coalition, or about midwifery and doula options in the St. John's area, telephone: 709-576-0642 or 709-754-8553.

Prince Edward Island, New Brunswick, Nunavut/NWT, Yukon, did not submit reports. However, there was comment and concern expressed by a nurse at the examination writing session about the home births occurring in New Brunswick. The CCM/CCSF has no knowledge of who is attending all of these.

A Visit to the Safe Motherhood Project, Ghana, submitted by Kay Matthews.

In May 1999, I went to Ghana to assess the Matercare primary prevention programs and give advice and support as necessary. The programs are based at St. Theresa's Hospital, Nkoranza, a small bush town in the Brong Ahafo region of central West Ghana. I spent two weeks in the Nkoranza area, visiting rural maternity centres, traditional birth attendants' (TBAs) birthing rooms, the hospital and the TBA training program. In 1998 there were 967 births and 4 maternal deaths at St. Theresa's Hospital.

Unlike in Canada, birth for most women in Ghana is quite hazardous, especially in rural areas. Most women give birth in their homes or rural clinics, far from emergency maternity care. The majority are delivered by TBAs, village women who have minimal or no formal training. One of the major objectives of the maternal mortality prevention program is to train the TBAs in safe delivery practice and to recognize mothers with risk conditions and refer them to hospital. When I arrived in Nkoranza the first group of TBAs had almost completed their two-week training program. At the end of the week we graduated 34 TBAs and supplied them with delivery kits and certificates. This was a joyful occasion because the TBAs were going home. They had left their families behind and lived in the hospital compound for the two weeks of the course. In all, we will train 110 TBAs, at least one from each village in the district.

A second objective is to introduce the partograph to the trained midwives in the rural maternity centres. The partograph, a World Health Organization (WHO) recommended tool for assessing the length of labour, helps the midwives recognize when labour is beoming prolonged, a dangerous situation for mother and baby. Some advice was needed in some of the centres, but partograph use had increased and, more significantly, referrals to St. Theresa's Hospital for delivery had increased.

Hospital staff, rural midwives and the TBAs were looking forward to the arrival of the ambulance service which Matercare International is providing for the emergency transport of

mothers to hospital. The fully-equipped ambulance, which will link the rural clinics with the hospital by radio, is due to arrive in July and we had to make sure the protocols were in place for the proper use of this emergency service. Meanwhile, renovations were going ahead in the hospital laboratory to house the modern Blood Bank which should be installed and equipped by August. A major cause of maternal death is haemorrhage, so this is an essential service for mothers who haemorrhage before, during, or after birth.

On one of my last visits to an isolated maternity centre, we passed through Baoteng village. This is a large village without a maternity centre. Most of the births are conducted by two TBAs. We saw one of the TBAs who had just completed her training with the Matercare Safe Motherhood team and stopped to see how she was doing. She told us they had just had a delivery and led us to the house where the mother and new baby lay. Both mother and baby were well, although the mother was tired. This was a happy ending to a long day.

Book Reviews and Articles

Mothers and Illicit Drugs. Transcending the Myths by Susan C. Boyd. (1999). Published by the University of Toronto Press. ISBN 0-8020-4331-3 (cloth), 0-8020-8151-7 (paper). This book is based on the qualitative research that Susan Boyd carried out for her thesis.

The first chapter is a literature review and is called "A Gender Analysis". The idea that women who take illicit drugs are bad mothers is a myth. There is no evidence that there are differences between abuse of illicit drugs and abuse of legal drugs which include alcohol, nicotine, and prescription drugs. Parenting values are similar for both mothers who take drugs and those who do not. Technology has advanced so that medical people are able to take over control of the fetus and predict fetal well-being separate from the mother's well-being. Pregnancy and birth have become defined as medical events. "Therapeutic abortion committees no longer exist in Canada, and women have improved access to abortion. Since the advent of legal abortion in Canada the fetal rights movement has gained considerable leverage" (p. 20). Mothers are blamed for the effects of drugs which they may have taken during pregnancy, but doctors are not blamed if they prescribe drugs with teratogenic effects.

Midwives who had "traditionally been the guardians of normal birth" (p. 19) have been prevented from practising legally in Canada. Women could no longer "define their own experience of birth, menopause, and menstruation" (p. 19) and have rebelled "against the medical profession's moral stance on their proper role in the family and in society" (p. 10, citing Mitchinson, 1991). The benefits of midwifery are again mentioned on pages 67-68. "Pregnant women want continuity of care during pregnancy that is supportive, sympathetic and provided by other women. Indeed it appears that this type of support is more effective than medical interventions during pregnancy" (p. 35, citing Oakley 1992). "Furthermore, woman centred midwifery support is both safe and inexpensive" (p. 35).

The participants in this study were both visible and non-visible drug users. There were 24 women who lived in Vancouver and 4 who lived in the Prairie provinces. The women were chosen through a snowball sampling and no woman was recruited from a clinic or a prison. The requirement was that the women had used opiate derivatives and/or coca derivatives (cocaine,

crack) for more than one year. The women were aged from 20 to 51 years, and the mean age was 35. Seven women were married or living with a partner, 2 were widowed, and 19 were single. Only 10 women had not completed high school and 6 had university degrees, 20 were on welfare (and five of these were attending university or college full-time). Between them the women had 59 children and 14 were labelled with Neonatal Abstinence Syndrome (NAS).

The remaining six chapters provide the results of the study including the women's perceptions of illicit drug use and mothering, the NAS program at Sunny Hill Hospital for Children, Social Services, drug treatment and the effects of the criminalization of narcotics. The last chapter provides implications for policy makers. The Appendix contains the interview schedule and replies of the women to these questions are given in the research findings throughout the book. There are 20 pages of References.

Boyd "shows that women of colour and poor women are treated much more harshly by authorities, that current regulations erode women's civil liberties, and that social control is the aim of drug policy and law". The "programs in England and Scotland strongly suggest that women's social and economic environment shapes maternal health when women are offered non-judgmental midwifery services and social and economic support. Maternal outcomes are similar to those seen in non-drug-using mothers" (p. 210).

(This book is on order for the QE2 Library at MUN, and so health care personnel will need to request their agency's library to obtain it for them via interlibrary loan).

The New Midwifery: Reflections on Renaissance and Regulation (1997). This 366 page, soft-covered book, edited by Farah M. Shroff, is published by Women's Press. The book is divided into two sections. The first section is "Midwifery, Diversity and New Agreements with the State" and considers the reclaiming of aboriginal midwifery, the effect of colonialism and loss of traditional midwifery practices in other countries. A chapter on "Midwives and Safe Motherhood" where Carol Hird and Brian Burtch consider "the redefinition of maternal deaths as a political problem helps to put women's status and mortality in a context that goes beyond physiology and medical intervention" (p. 134). "With few exceptions, feminist writing rarely touches on maternal mortality" (p. 135). "The World Health Organization regards the midwife as the key person in the maternal health care pyramid. . . . State regulation may of course undermine midwifery practice" (p. 137). "In Canada or elsewhere, a failure to consider the legacy of colonialism in the South obscures structural forces of racism, poverty and educational barriers that continue to place many women at risk" (p. 138). Cecilia Benoit has a chapter looking at the sociological perspectives of midwifery. She discusses the Swedish model where midwifery is legitimized by the State, but there is no room for home births. Swedish women appreciate the care and teaching given by midwives, such as with breastfeeding, and parenting.

Pat Israel's chapter is about the experiences of mothers with disabilities. She is involved with the Disabled Women's Network (DAWN) Ontario. She includes a list of resources (but I was unable to access the DAWN web site, as it could no longer be located). Some of this is repeated in the second section, in the chapter by Shroff (who was in Ontario but has now relocated to BC). In the chapter "All Petals of the Flower" she provides the content of a primer

Diversity Dynamics which was developed for use in the Ontario midwifery education program. An interesting item in the list of resources is a one-hour video produced by Pauktuutit and the Inuit Broadcasting Corporation: *Ikajurti (The Helper)*: *Midwifery in the Canadian Arctic*. This film is available from Pauktuutit. Although aboriginal women are encouraged to enter the Ontario midwifery program there is a low representation of minority groups. This is also discussed in a chapter on "Prior Learning Assessment for Midwives and the TECMI-Coloured Dreamcoat", a Toronto East Cultural Mentorship Initiative which was started to help Chinese students enter the program and then to practice amongst the Chinese population in this part of the city. Bursaries were provided but only two students availed themselves of these and only one graduated.

The second section of the book is about "State Regulation of Midwifery Across Canada". Since these chapters were written there have been many changes. Alison Rice's chapter on "Becoming Regulated in British Columbia", and Susan James' chapter about regulation in Alberta (both implemented in 1998) demonstrate that how it is expected that midwifery will proceed does not necessarily happen that way. For example, the Alberta government has not completely funded midwifery, so there is a two tiered system; either have a doctor for free or pay for a midwife and the choice of place of birth, continuity of care, etc. The chapter by Mary Sharpe is about midwifery in the first year following midwifery legislation coming into effect in Ontario in 1994. Once again, the expectations did not materialise, such as having three birth centres

The chapter by Marie Hatem-Asmar and Regis Blais on midwifery in Quebec is a longer version of the 1996 article "A Survey of Midwives in Quebec: What are their Similarities and Differences?" *Birth, 23*(2), 94-100. Of course, since then the Bill 4 pilot project has been evaluated and the use of the birth centres has been extended until September 1999, pending the government passing legislation for midwives to be licensed. Also, a midwifery degree program commences in September 1999.

The Rankin Inlet, NWT, Birth Centre Project is described by Maureen Morewood-Northrop, a British trained midwife who worked as a nursing consultant for the NWT Government, but has since retired. This project has been evaluated and now continues as a birth centre.

Charlene MacLellan, a midwife in Nova Scotia, writes about "Midwifery in Atlantic Canada" (see the end of our Midwives Association's Newsletter, No. 6, September 1998). She uses her own experiences with home births to describe Nova Scotia midwifery. She also states that "Newfoundland and Labrador, however, continued to employ nurse-midwives in cottage hospitals and in regional centres. This was mainly due to the unavailability of physicians in remote areas and the birth culture of arriving immigrants from Britain who were accustomed to hospital-based midwifery. This practice of nurse-midwifery is still present today in Newfoundland and Labrador" (p. 332). She has followed the publisher's wishes by avoiding the "Mission" issue by not mentioning Wilfred Grenfell, but neither has she mentioned NONIA, nor the 1920 Midwives Act. She cites information from *Feminism and Midwifery*, a 1990 thesis by Margot Jean Ferguson-Parker as part of the fulfillment of a degree at Acadia University,.

There is a problem when someone starts writing about another province. An example that has been brought to my attention is about Saskatchewan. At present the Saskatchewan

government has agreed to the establishment of a Transitional Council until there are sufficient midwives registered for the equivalent of a College of Midwives, but has not settled on the method of funding. In this book it predicts that Saskatchewan "will probably adopt midwifery in a similar manner to the whole-hearted support that the NDP gave it in Ontario" (p. 360). Also, "In Saskatchewan those shaping the regulation of the profession are hoping that 4% of the births will be midwifery assisted" (p. 359) whereas the Saskatchewan midwives are predicting a higher percentage. I understand that the percentage figure originated from an out-of-province source.

Much is happening very quickly regarding midwifery in Canada. This book is interesting because of the history of midwifery in Canada when written by those living in the province/territory at the time of the occurrences. Now, with hindsight, it can be seen that the future has not always been as was predicted. One also realizes that the other provinces have historical and current information on traditional birthing practices by aboriginal groups, written by aboriginal people, which we in Newfoundland and Labrador do not have readily available.

Feminism and Midwifery by Margot Jean Ferguson-Parker. (1989). Unpublished BA (Honours) thesis. Acadia University, NS.

This research examined feminist and pro-midwifery texts to analyze how the ideologies of childbirth common to the post-1970 midwifery movement have been addressed. The author was interested in studying conflicting viewpoints because her grandmother was a pre-1950s midwife practising in rural New Brunswick. To study this topic a feminist approach was used based on Aker, Barry and Easeveld (1983) that "It should contribute to women's liberation through producing knowledge that can be used by women themselves; should use methods of gaining knowledge that are not oppressive; should continually develop a feminist critical perspective that questions dominant intellectual traditions and can reflect upon its own development" (p. 423). Childbirth was considered to be "concerned with both the physical act of birthing, as well as the delineation of appropriate and inappropriate, physical, social, and psychological locations for birth" (p. 12). The printed materials consisted of both primary and secondary sources. Primary sources were written by midwives and their supporters and were directed mainly at pregnant women. The author had a problem classifying the literature as writers, such as Kitzinger, have both feminist and pro-midwifery views. The literatures which were analyzed were feminist texts; lobby group newsletters (Midwifery Coalition of Nova Scotia, 1989-1990); parenting magazines (*Mothering*, 1986-1990, the issues which contained relevant articles); books about childbirth. The pro-midwifery texts used were Ina Gaskin's (1977) *Spiritual Midwifery*; Suzanne Arms' (1975) *Immaculate Deception*; Sheila Kitzinger's (1977) *The Midwife Challenge*.

Some feminists consider motherhood as the reason why women exist. This debate was opened by Beauvoir (1953) in her book *The Second Sex*. Birth control is just a means of delaying motherhood, not of rejecting it. Other writers praise midwifery (O'Brien, 1981, Rich, 1986) as having a woman-centred approach that has the potential for undermining the male dominated medical system. Traditional midwives, like the grandmother, did not practice with the intent of releasing women from the oppression of medicalized childbirth, nor to submit them to male domination. They practiced because there was a need for their skills. Rich was found to be inconsistent, as she disagreed with Kitzinger but agreed with Arms, when both of these authors

have similar points of view. O'Brien wished for the return of midwifery but did not consider all of the changes which had occurred since she had once practiced. Feminist writers expressed opinions of childbirth and reproduction but precluded the approval of some of the "new" midwifery's ideologies and practices, and rarely interviewed consumers. The pro-midwifery group did provide the views of clients.

The idea of choice is given by the pro-midwifery groups. Arms considered that the midwife stood on the side of woman's free choice in birth. Liberal feminists, however, consider that free choice requires responsibilities "rational and informed decision-making based on equally available options is the way to achieve gender equality, and women must take this responsibility seriously" (p. 39). But, incorporating others, e.g., partner, in the decision making restricts the amount of choice. Midwives and liberal feminists may have a different concept of what "choice" is. Often feminists do not mention childbirth, but motherhood and fatherhood are recurring topics (for example, Friedan, Betty, 1976).

Marxist feminists are concerned with private and public space, and moving births from a private area to a public place represents the medicalized control of births. Medicine is where the child is produced by specialists (capitalists) and their technology. Midwifery keeps the child with the mother (the worker) (p. 47). In previous decades middle class women had demanded to have their babies in hospitals, but now they were wanting to move away from the hospital back to the home. "In Newfoundland and Labrador, and in areas of the north, as well as in rural pockets here and there throughout the country, neighbours continued to help one another at times of childbirth. But, in all these places there was increasingly a consciousness that unmedical birth was on its way out, that it was a stop-gap until there were sufficient hospitals and doctors to enable all births to be conducted 'properly'" (pp. 26-27, citing Mason, 1988, p. 118). Benoit (1989) also wrote that "Newfoundland and Labrador continue to employ nurse-midwives in the regional and referral hospitals" (p. 638). [In the early 1980s nurses who were midwives were not permitted to practice except in St. Anthony and Goose Bay, so it is not known from where this information was obtained. This is also cited in *The New Midwifery*].

The evaluation revealed that various feminist theories normally reflected a superficial understanding of the ideologies of childbirth which were evident in the pro-midwifery literature. Marxist feminist seldom look at midwifery, although Benoit is an exception. Radical feminists shun biological reproduction. Psychoanalytic feminists expand motherhood to understand more about childbirth, and consider the social and psychological dimensions rather the physical aspects. Socialist feminist both agree with and diverge from midwives. Existential feminists need to debate whether transcendence for women can come about even when they acknowledge their reproductive capacities. Post-modern feminists do not give much consideration to childbirth and midwifery.

Unless government funding is available midwives are only for the people who can afford to pay them and are of the right culture, age and health. Little notice has been taken when the midwifery movement has perpetuated the same inequalities as the medical system, but much notice is taken when women are oppressed by the medical system. Woman-centred care for feminists is "choice in reproduction" whereas for midwives it is birth where the mother wishes with the attendants the mother wants. Feminists and midwives consider "traditional" ways of birth idealistic and involved females, but have not considered the historical facts. Midwives are

controlled by external agents, such as government legislation, which restrict the practice and women's accessibility to them.

The author's conclusion is "that feminist theorist's support or rejection of midwifery be assessed by giving closer scrutiny to the ideologies which advocates of midwifery have generated".

References

Benoit, C. (1989). Traditional midwifery practice. The limits of occupational autonomy. *Canadian Review of Sociology and Anthropology, 26*(4), 633-649.

Friedan, B. (1976). *It changed my life*. New York: Random.

Kuusisto, K. M. (1980). *Midwives, medical men and obstetrical care in nineteenth century Nova Scotia*. Unpublished MA thesis, University of Essex.

Mason. J. (1988). Midwifery in Canada. In S. Kitzinger (Ed.), *The Midwife Challenge*. London: Pandora.

Misoprostol - Benefit or Caution? , by Helen Rees. (1999, March). *IPPF Medical Bulletin, 33*(2), 5-6.

"Misoprostol (Cytotec) is a synthetic prostaglandin E1 analogue registered in many countries for the prevention of peptic ulceration in patients taking non-steroid anti-inflammatories. The medication has received much attention in recent years because of its widespread unregistered use in obstetrics and gynaecology for various conditions and interventions. While the manufacturer (Searle) is uncomfortable about this aspect of its use, clinicians all over the world are researching misoprostol's potential for revolutionising the management of several common conditions in women. Misoprostol has many characteristics that make it an attractive prospect for use in obstetrics and gynaecology particularly for developing countries. It is cheap, is stable at room temperature, is rapidly absorbed both orally and vaginally, has few side-effects for the woman taking it, and is available in many countries. Misoprostol acts by stimulating uterine contractions, and the pregnant uterus is particularly sensitive, although the effect on uterine muscle varies with length of gestation.

In the first trimester, a single dose of misoprostol has proved more effective than placebo in dilating and softening the cervix before termination of pregnancy, particularly under 10 weeks' gestation. This makes the subsequent surgical procedure faster and easier to perform, and probably safer. In some cases, and particularly when the dose of misoprostol is repeated, first trimester abortions can be induced. However, because abortion is not reliably induced and may be incomplete, it is recommended that this procedure be followed up with a definitive surgical procedure to evacuate the uterus. . . .

In the second trimester of pregnancy, misoprostol is very effective in inducing abortions but uterine rupture has been reported, particularly where women have used misoprostol without medical supervision. Similarly, misoprostol has been successfully used for the induction of labour in women with late fetal death. Research has also confirmed the safety and efficacy of small doses of intravaginal misoprostol as an agent for cervical ripening and labour induction in patients with a full-term pregnancy. The use of misoprostol to reduce the risk of postpartum haemorrhage is being investigated by the World Health Organization. With all these indications

for misoprostol in obstetrics and gynaecology, a small proportion of women are resistant to its use even with repeated dosage.

With so many benefits, why is the use of misoprostol controversial? In recent years there have been reports from all over the world of the widespread self-administration of misoprostol by women trying to induce abortion. Reports from Brazil described a range of abnormalities, including the Mobius sequence and abnormalities of limbs and cranium, in children born to women who had used misoprostol in unsuccessful attempts to induce first trimester abortions. . . . The most recent report on teratogenesis for the first time produces more convincing evidence that misoprostol may cause Mobius sequence in affected infants. In addition to this concern, uterine rupture is a small risk when misoprostol is used without proper medical supervision in the second and third trimesters of pregnancy. . . . The new indications for misoprostol use should be formally recognised and registered by a pharmaceutical company, so that ethical and safe guidelines for its use can be promoted". (There are 8 references given).

Misoprostol Caution (forwarded from the internet by Anessa Maize of Winnipeg).

The opinion of the best perinatal scientists is that misoprostol (cytotec) induction is still experimental and should only be done in a controlled research setting with the usual protection of research subjects including fully informed consent. This is because to date our scientific data are inadequate to tell us whether or not misoprostol induction is safe. How to hold back the rapid spread of misoprostol induction, which heralds the return of all the convenience of daylight obstetrics? That the drug is not approved by the FDA for this purpose, not approved for this use by the drug manufacturer, not endorsed for this use by the American College of Obstetricians and Gynecologists or midwifery organizations and not recommended for routine use by scientists (who tell us we do not know if it is safe) has had no apparent effect on the enthusiasm with which clinicians, both doctors and midwives, are starting to use it . . . . Midwives need to make every effort to achieve evidence based practice, particularly when using drugs and invasive technologies, and the clear lack of data on serious risks of misoprostol induction should be sufficient to deter all midwives from this procedure, whether in hospital or out of hospital. The issue here is consumer protection and quality assurance in maternity care. We need a system of rational pharmaceutical management which guarantees adequate evaluation of every use of a drug prior to its use for that purpose and drug protocols developed by an officially recognized group of scientists, clinicians (including midwives), policy makers and consumers and based on the best scientific evidence. Present consumer protection systems in some countries, for example in Scandinavia, include mandatory prior evaluation and officially endorsed consensus protocols, and there is no evidence that progress in maternity care is held back. -Marsden Wagner, MD, "Misoprostol (Cytotec) for Labor Induction: A Cautionary Tale," Midwifery Today Issue No. 49, Spring 1999

Asthma Watch. Exclusive Breastfeeding, (1999, May 10). *Maclean's, 112*(19), 62.

Exclusive breastfeeding in the first four months of life appears to protect children from asthma at least up to the age of 6, according to an Australian researcher, Wendy Oddy. . . .Of a study of 3,000 babies half were fed only breastmilk for their first four months while the others were fed by breast and bottle or by bottle alone. Oddy and her team found asthma, wheezing and

sleep disturbances caused by respiratory symptoms, as well as sign of allergies, to be more common among the babies who were not exclusively breastfed. Oddy noted that breastmilk contains a unique combination of substances essential to the development of the immune system. . . . Boston researchers reported that in a study involving 16,862 children aged 9 to 14, they found the heaviest group to be 1 ½ to two times more likely to develop asthma than their thinner peers".

Chandra, R.K. (1996). Five-year follow-up of high risk infants with family history of allergy who were exclusively breast fed or fed partial whey hydrolysate, soy and conventional cow's milk formulas. *Journal of Pediatric Gastroenterology and Nutrition, 24,* 380-388. In Newfoundland it has been found that about 15% of children have a family history of allergies, and the average cost of treating a child until the age of 5 years who has allergies is about $740,000 per year. In Chandra's study, 216 high-risk infants whose mothers had elected not to breast feed were randomized to receive exclusively a partial whey hydrolysate formula or a conventional cow's mild formula or a soy formula until 6 months of age. Seventy-two high risk infants breast fed for $\geq$ 4 months were also studied. Follow-up until 5 years of age showed a significant lowering in the cumulative incidence of atopic disease in the breast fed (odds ratio 0.422[0.200-0.891]) and the whey hydrolysate (odds ratio 0.322[0.159-0.653]) groups, compared with the conventional cow's milk group. Soy formula was not effective (odds ratio 0.759 [0.384-1.501]). The occurrence of both eczema and asthma was lowest in the breast-fed and whey hydrolysate groups and was comparable in the cow's milk and soy groups. Similar significant differences were noted in the 18-60 month period prevalence of eczema and asthma.

Soy-based Baby Food May Pose Developmental Risk, Groups says by D. Bueckert, *Globe and Mail*, June 8, 1999, p. A9.

Soy-based infant formula and baby food may disrupt the normal sexual development of children, health advocates say. Compounds known as phytoestrogens - natural estrogens derived from plants - are found in soy formula. Studies have shown them to disrupt sexual development and behaviour in animals, Elisabeth Sterken of the Infant Feeding Action Coalition said yesterday. She suggested the use of such formula in the past 30 years may be linked to the well-documented earlier onset of puberty in developed countries. "The use of soy-based formula must be restricted immediately until the industry demonstrates the safety of phytoestrogens", Ms. Sterken said at a news conference.

The Infant Feeding Action Coalition is a non-profit group that promotes breastfeeding. Ms. Sterken's warning was backed by the Canadian Health Coalition and the National Federation of Nurses Unions. A federal Department of Health official said there's no direct evidence that soy-based formula is hazardous, but the department is monitoring scientific debate.

Soy-based formula, first introduced in the 1960s, is often used by mothers who believe their child is allergic to cow's milk. Its popularity has been growing, and an estimated 20 per cent of Canadian babies now take it. Phytoestrogens occur naturally in soybeans and don't pose any threat to adults, but reputable scientific journals have raised concerns about their effects on newborns during a crucial period of sexual development. Exposure to such compounds "may pose a development hazard to infants", an article in the journal of the *Society for Experimental Biology and Medicine* said last year.

Antibiotics, (1999, April 19), *Maclean's, 112*(16), 56.

A study carried out by researchers at Memorial University have looked at prescriptions issued by 476 of the province's general practitioners over a one-year period. They found that high-volume fee-for-service physicians were 4.7 times more likely to be high prescribers than salaried doctors, who work mainly in the province's thinly populated rural areas. The rates of antibiotic use far exceeded infection rates. Antibiotic prescriptions may be viewed by fee-for-service physicians as necessary to cope with high daily patient numbers and to retain patients in their practices. The overuse of antibiotics had led to the emergence of dangerous strains of antibiotic- resistant bacteria. This study is published in the *Canadian Medical Association Journal*.

Timing of Emergency Contraception (1999, April), *IPPF Medical Bulletin, 33*(2), 6.

The WHO trial on emergency contraception has re-examined their earlier data and have found a consistent linear relationship between efficacy and time from intercourse to treatment: pregnancy rates increased from 0.5% when treatment was given within 12 hours to 4.1% when it was given between 61 and 72 hours. They then applied logistic regression, to allow for possible confounding by the women's characteristics; but, after adjustment for indices such as age, weight, gravidity, cycle length, and day of cycle the results remained almost unchanged. For each 12 hours of delay the odds ratio of pregnancy was 1.46 (95% confidence interval 1.20-1.77). In other words, delaying the first dose of emergency contraception by 12 hours increases the odds of pregnancy by almost half.

Single Room Maternity Scores High for Nurses! From AWHONN Canada, March 1999.

A recently completed evaluation of single room maternity care (SRMC), as an alternative to traditional labour/delivery then separate postpartum rooms, reported high levels of satisfaction on the part of both nurses and patients. Nurses completed a questionnaire about their satisfaction with many aspects of their work before they started working in the new 7-bed demonstration unit at BC Women's Hospital. When compared with their scores six months after working in the unit there was significant improvement in all areas measured. The areas where the nurses in SRMC felt disadvantaged were in nursing staffing levels and availability of medical staff. Since so few (20) nurses were cross-trained to work in SRMC it was difficult to find nurses in other areas who could come and relieve for breaks. Some physicians were reluctant to come to SRMC to see their patients as it was on a different floor than the rest of their labouring patients.

SRMC patients scored significantly higher on questions relating to information and opportunities for making information choices during labour. They were more likely to report that they spent the right amount of time with their support person and baby, that they received enough rest, were less bothered by noise, and had fewer different caregivers in their room. They were discharged an average of 7 hours sooner than that of women in the other postpartum modules. Outcomes including rates of cesarean section, complications of labour, delivery and postpartum, did not differ between the groups. A detailed financial report will be available in the Fall 1999.

CNA Policy Statement

Evidence-Based Decision-Making and Nursing Practice.
Contact CNA for a copy. Telephone: 1-800-361-8404

AWHONN eNEWS, May 1999

SNORING BY PREGNANT WOMEN AND THE RISK OF PRE-ECLAMPSIA~

A recent report suggests the presence of a link between snoring by pregnant women and an increased risk of pre-eclampsia. Note: pre-eclampsia is characterized by a significant increase in maternal blood pressure during pregnancy. Researchers at the University of Sydney, Australia, studied snoring in 32 pregnant women with severe pre-eclampsia and 14 women with normal pregnancies to collect data, found that all of the pre-eclamptic women developed snoring during pregnancy, compared to fewer than half of the women with normal pregnancies, and that the highest blood pressure levels were associated with increased rates of both partial airway obstruction and snoring. Authors say the findings suggest that snoring therapies, such as continuous positive airway pressure using a mask, may be useful in minimizing airway obstruction and improving nocturnal blood pressure in pre-eclamptic women. The report was presented by the University of Sydney's Dr. Colin Sullivan at the American Lung Association/American Thoracic Society International Conference in San Diego (April 27, 1999).

~VITAMIN D AND FRACTURE RISK IN POSTMENOPAUSAL WOMEN~

A new study concludes that older women who have a vitamin D deficiency may be at increased risk of fractures, compared to similarly-aged women with no such deficiency. Authors say the findings suggest that taking vitamin D supplements or increasing sun exposure -- which increases the body's vitamin D production -- may reduce the increased fracture risk associated with age in this patient population. The study is in The Journal of the American Medical Association (1999;281:1505-1511).

~NEEDLE BIOPSY FOR BREAST CANCER DIAGNOSIS~

A new report concludes that large-core needle biopsy is a safe and accurate alternative to surgical removal of breast tissue for the diagnosis of possible cancer The report is in The Journal of the American Medical Association (1999;281:1638-1641).

~VOLUNTARY RECALL OF PLAS-SD~

V.I. Technologies is voluntarily recalling an additional eleven lots of PLAS-SD based on the results of additional testing for parvovirus B19 using validated PCR technology. There has been no evidence of clinical disease typical of parvovirus B19 associated with the transfusion of the of PLAS-SD. Parvovirus B19 most seriously affects pregnant women or immuno-compromised individuals. This document is available on CBER's Fax Information System at 1-800-827-3844 as document number #0702.

~VAGINAL INFECTIONS AND BLEEDING AND THE RISK OF PREMATURE BIRTH~

A recent study concludes that women who experience vaginal infections and bleeding during their first trimester of pregnancy are at increased risk of giving birth prematurely. Researchers at the Denver HealthMedical Center and the University of Colorado Health Sciences Center reviewed the records of more than 1,000 pregnant women who received prenatal care between January 1991 and March 1992 to collect data, found that the risk of preterm birth was increased 20% in women with bacterial vaginosis alone, 90% in those with first-trimester bleeding, and

400% in those with both bacterial vaginosis and gestational bleeding. Authors say the findings suggest that all pregnant women with vaginal infections, with and without bleeding, should be identified promptly and treated systematically using standard protocols. The study is in The Journal Obstetrics and Gynecology (1999;93:715-724).

~ INCREASED INFANT DEATH RISK ASSOCIATED WITH SHORTER PREGNANCY INTERVALS~ Researchers at the University of Chicago Children's Hospital analyzed birth and death data on almost one million U.S. infants born in 1990 to reach their conclusions found that infants conceived within 6-12 months of a previous delivery had a 39% increased risk of death from all causes, compared to those born further apart; those infants conceived within six months of a previous delivery were at double the risk of death. Authors note that infant deaths associated with biological complications, such as maternal complications, obstetrical and delivery complications, and birth defects were not particularly associated with short pregnancy intervals, but that those associated with child care practices (intentional abuse, accidental injury, etc.) increased significantly; shorter pregnancy intervals were also associated with a significantly increased risk of sudden infant death syndrome (SIDS). The findings were presented by University of Chicago Children's Hospital's, Dr. Babak Khoshnood at the annual meeting of the Pediatric Academic Societies in San Francisco (May 3, 1999).

~STERILE WATER INJECTIONS FOR LOWER BACK PAIN DURING LABOR~
A new study concludes that women treated with sterile water injections for lower back pain during labor experience less pain than women treated with other nonpharmacological methods. Researchers at the University in Quebec, Canada, randomized 34 women suffering from lower back pain during labor to receive either sterile water injections, standard therapy consisting of massage and whirlpool bath, or transcutaneous electrical nerve stimulation (TENS) to collect data. Found that women in the sterile water group reported significantly less pain than women in the other two groups during the experimental period, but that request rates for epidural anesthesia were similar between the three groups. Authors note that pain relief from the water injections lasted for 1-2 hours following an injection-related period of pain that lasted for 20-30 seconds. The study is in The Journal of Family Practice (1999;48:259-263).

~REDUCED RISK OF ATOPIC ECZEMA IN PREMATURE INFANTS~
A new report concludes that infants born prematurely at very low birth weight appear to be at significantly reduced risk of the allergic skin condition atopic eczema, compared to those born at term. Researchers at Humboldt University in Berlin, Germany, studied eczema incidence in 331 infants born prematurely and 455 born at term to collect data, found that 1.5% of premature infants experienced atopic eczema by the time they reached one year of age, compared to 4.6% of those born at term. Authors say the mechanism behind the reduced risk is not clear, but suggest that time spent in neonatal intensive care units by premature infants may expose them to more antigens, leading to the development of reduced future sensitivity to antigens. The report is in The Lancet (1999;353:1674).

Conferences As this information comes from a variety of sources the editor takes no responsibility for any errors.

July 2-3, 1999. "Regulation Across Borders: The People's Health and Professional Regulation", 4th International Conference on the Regulation of Nursing and Midwifery, London, England.
Cost: 176.25 pounds
Contact: Julie Robinson, UKCC, 23 Portland Place, London W1N 4JT, England. (Telephone: 011-44-171-333-6556; email: julierobinson@ukcc.org.uk)

July 17-18, 1999. "Reconceiving Midwifery: The New Social Science of Midwifery in Canada", Toronto. Co-sponsored by the University of Western Ontario and the Ryerson Midwifery Program.
Cost: $100' $40 for students and unemployed. Breakfast and lunch included.
Contact: Maggie MacDonald, Maggie MacDonald, Department of Anthropology, 2054 Vari Hall, York University, North York, Ontario, M3J 1P3 (Telephone: 416-531-1835; Fax: 416-533-0736, email maggie@yorku.ca)

August 23-27, 1999. "Social Policy in International and Transnational Context", Kingston, ON
Includes discussion on public health, families, child health.
Cost: Days 1 and 2; 3 and 4 $577.80 per two days; day 5 $291.60
Contact: Queen's Institute on Social Policy, 70 First Avenue, Ottawa, ON, K1S 2G2 (Telephone: 613-237-9812; E-mail: info@qiisp.com; Internet: http://www.qiisp.com)

September 9-13, 1999. "Evidence-Based Midwifery", annual Midwifery Today conference, London, England.
Cost: Before May 17 nonmember $275US, member $250US/before July 15 nonmember $300US, member $275US/before August 24 nonmember $325US, member $300US
(Note: The flyer had 1998 dates against a 1999 conference, presumably a typo).
Contact: Midwifery Today, P.O. Box 2672, Eugene, OR 97402, USA (Telephone: 1-800-743-0974; E-mail: midwifery@aol.com; Internet: http://www.,midwiferytoday.com)

September 24-25, 1999. "Breastfeeding Challenges: Evidence-Based Practice", Toronto.
Contact: Joyce Ridge, telephone: 416-586-4543; fax: 416-586-8653.

October 15, 1999. "The Environment of Women's Health", St. John's.
Abstract: June 30, 1999.
Contact: Women's Health Network, Nurses Residence, Grace Hospital, 214 LeMarchant Road, St. John's, NF, A1E 1P9 (Telephone: 709-778-6534; Fax: 709-778-6533; E-mail: whnmun@morgan.ucs.mun.ca)

October 29, 1999. Breastfeeding, Breast Health & Women's Health, AWHONN Conference, Halifax.
Contact: Faith Wight Moffatt, School of Nursing, Dalhousie University, 5869 University Avenue, Halifax, NS, B3H 3J5 (Fax: 902-494-3487; E-mail: faith.wight.moffatt@dal.ca

November 18-19, 1999. "Canadian Cochrane Symposium. Impact of the Cochrane Collaboration: Past, present, and future", Hamilton, Ontario. November 18 is Reviewer Training - Beginner's Workshop. November 19 is Plenary Sessions, Papers & Mini Workshops. These are followed on November 20 with the annual general meeting.
Cost: $100/$50 for full time students and members.
Contact: Canadian Cochrane Centre, c/o Health Information Research Unit, McMaster University, 1200 Main Street West, Room 3H7, Hamilton, ON, L8N 3Z5 (Fax: 905-546-0401; e-mail: cochrane@fhs.mcmaster.ca; internet: http://hiru.mcmaster.ca/cochrane/centres/canadian/
(Abstracts: http://hiru.mcmaster.ca/cochrane
Full neonatal reviews: http://silk.nih.gov/silk/cochrane)

December 2-6, 1999. "Birth Without Borders - Weaving a Global Future", Midwifery Today International Conference, Ocho Rios, Jamaica.
Contact: Midwifery Today, P.O. Box 2672, Eugene, OR 97402, USA (Telephone: 1-800-743-0974; E-mail: midwifery@aol.com; Internet: http://www.,midwiferytoday.com)

2000

May 11-13, 2000. "2000 Manitoba: Prairie Province Conference on FAS", Winnipeg.
Abstracts by August 1, 1999.
Contact: Dawn Ridd, Youth and Children Secretariat, 100-233, Portage Avenue, Winnipeg, MB, R3B 2A7 (Fax: 204-948-2585).

May 24-26, 2000. "In Touch with Our Tomorrow's Today. Visions for a New Millennium of Sustainable Health, Healing, Wellness and Renewal", Churchill. Focus is the development of directions for the sustainable advancement for population health in the Hudson Bay Bioregion through the next millennium.
Abstracts: Due now for: presentations, posters, workshops on research, case reports, traditional values, aboriginal lifestyles, crosscultural interactions etc.
Contact: Brenda Wohlgemuth, Churchill Regional Health Authority Inc. (Fax:204-675-2243; e-mail: crharpa@cancom.net)

May 28-30, 2000. "Charting the Course for Literacy and Health in the New Millennium", 1st Canadian Conference on Literacy and Health, Ottawa. For health professionals, academics and community-based researchers, health administrators and policy makers, pharmaceutical companies, literacy practitioners and advocates, and health consumers with low literacy skills.
Contact: Canadian Public Health Association Conference Department, Suite 400, 1565 Carlin Avenue, Ottawa, ON, K1Z 8R1 (Fax: 613-725-9826; E-mail: conferences@cpha.ca; Internet: http://www.nald.ca/nlhp.htm)

June 18-21, 2000. "Convention 2000", Vancouver.
Contact: Canadian Nurses Association, 50 Driveway, Ottawa, ON, K2P 1E1 (Telephone: 1-800-361-8404)

unicef

Breastfeeding Papers of the Month 1998

UNICEF Nutrition Section, New York

JANUARY

Breastfeeding and Later Cognitive and Academic Outcome
Horwood, L.J.., Fergusson, D.M. Pediatrics, 1998; 101 (1): 01-07.

FEBRUARY

Bedsharing Promotes Breastfeeding
McKenna, J.J., Mosko, S.S., Richard, C.A. Pediatrics, 1997; 100(2): 214-219.

MARCH

Cross-cultural Patterns of Growth and Nutritional Status of Breast-fed Infants
Dewey, K.G. American Journal of Clinical Nutrition, 1998; 67; 10-17.

APRIL

Breastfeeding and Intelligence. Optimizing Beneficial Fats in Breastmilk.
E. Sterken. INFACT/IBFAN Newsletter, Toronto: Winter 1998.

MAY

Does Early Supplementation Affect Long-Term Breastfeeding?
P.D. Hill, S.S. Humenick, M.L. Brennan, D. Woolley.
Clinical Pediatrics, 1997; 36(6): 345-350.

JUNE

Bonding: Recent Observations That Alter Perinatal Care.
J.H. Kennell, M.H. Klaus Pediatrics in Review, 1998; 19: 04-12

JULY

The Influence of Breastfeeding on the Development of the Oral Cavity: A Commentary
Palmer, Brian. J Hum Lact, 1998; 14(2): 93-98

AUGUST

Breastfeeding Promotion in a Diarrhoea Programme in Rural Communities
Davies-Adetugbo, A.A., Adetugbo, K., Orewole, Y., Fabiyi, A.K. J Diarrhoeal Dis Res, 1997; 15(3): 161-166

SEPTEMBER

Impact of Community Organization of Women on Perinatal Outcomes in Rural Bolivia
O' Rourke, K., Howear-Grabman L., Seoane, G. Rev Panam Salud Publica/ Pan Am J Public Health 1998; 3(1): 9-14

OCTOBER

International Multicentre Pooled Analysis of Late Postnatal Mother-to-Child Transmission of HIV-1 Infection.
V. Leroy, M.L. Newell, F. Dabis, C. Peckham, P. van de Perre, M. Butlerys, C. Kind, R.J. Simonds, S. Wiktor, P. Msellati. The Lancet, 1998; 352: 597-600.

NOVEMBER

The NCHS Reference and the Growth of Breast-and Bottle-Fed Infants.
C.G. Victoria, S.S. Morris, F.C. Barros, M. de Onis, R. Yip. American Society of Nutritional Sciences, 1998; 1134-1138.

Growth Patterns of Breastfed Infants and the Current Status of Growth Charts for Infants?
K.G. Dewey. J. Hum Lact, 1998; 14(2): 89-92.

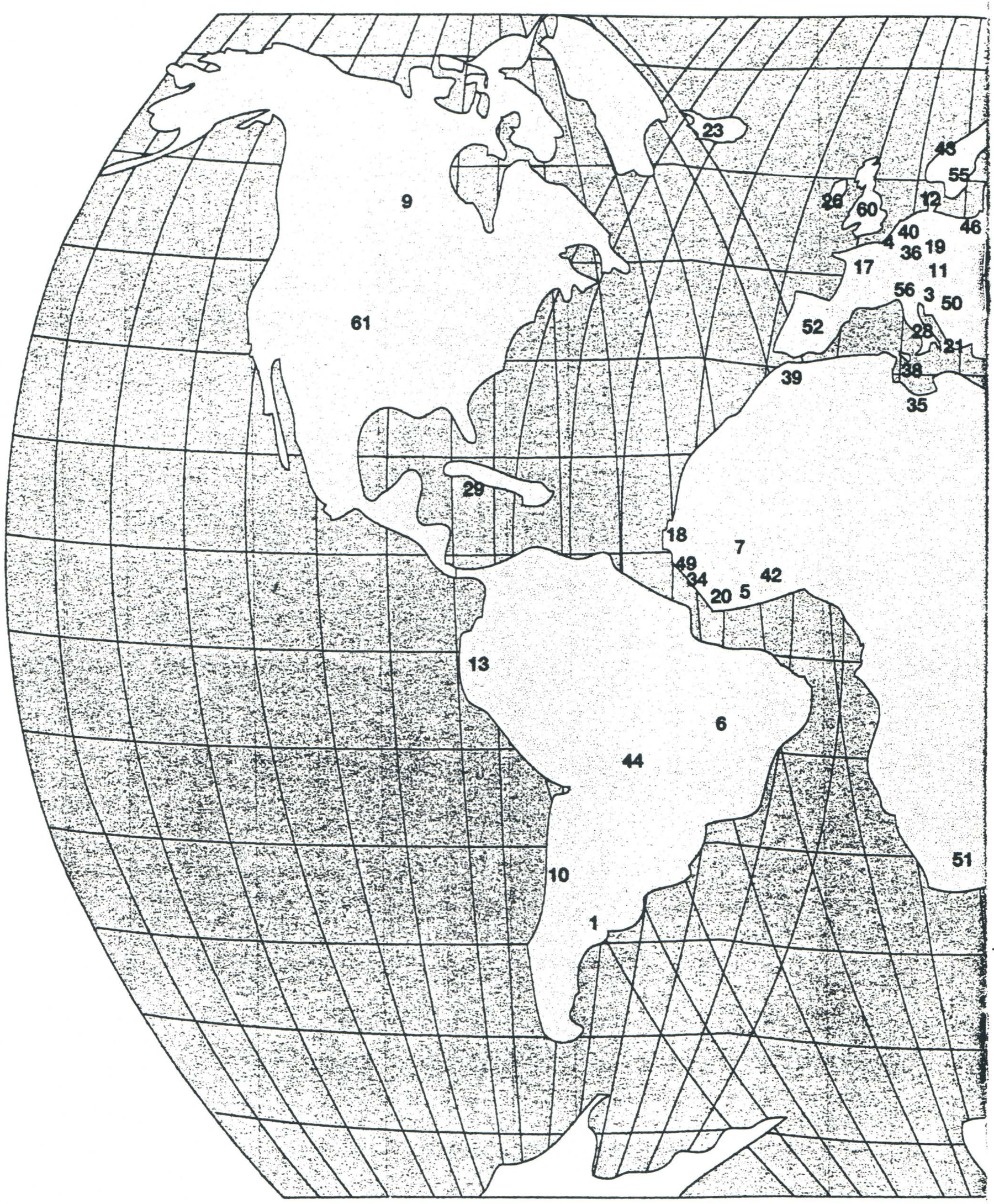
DECEMBER

Kangaroo Mother Care in Low-income Countries.
Cattaneo, A., Davanzo, R., Bergman, N., Charpak, N. Journal of Tropical Pediatrics, 1998; 44: 279-282

WABA

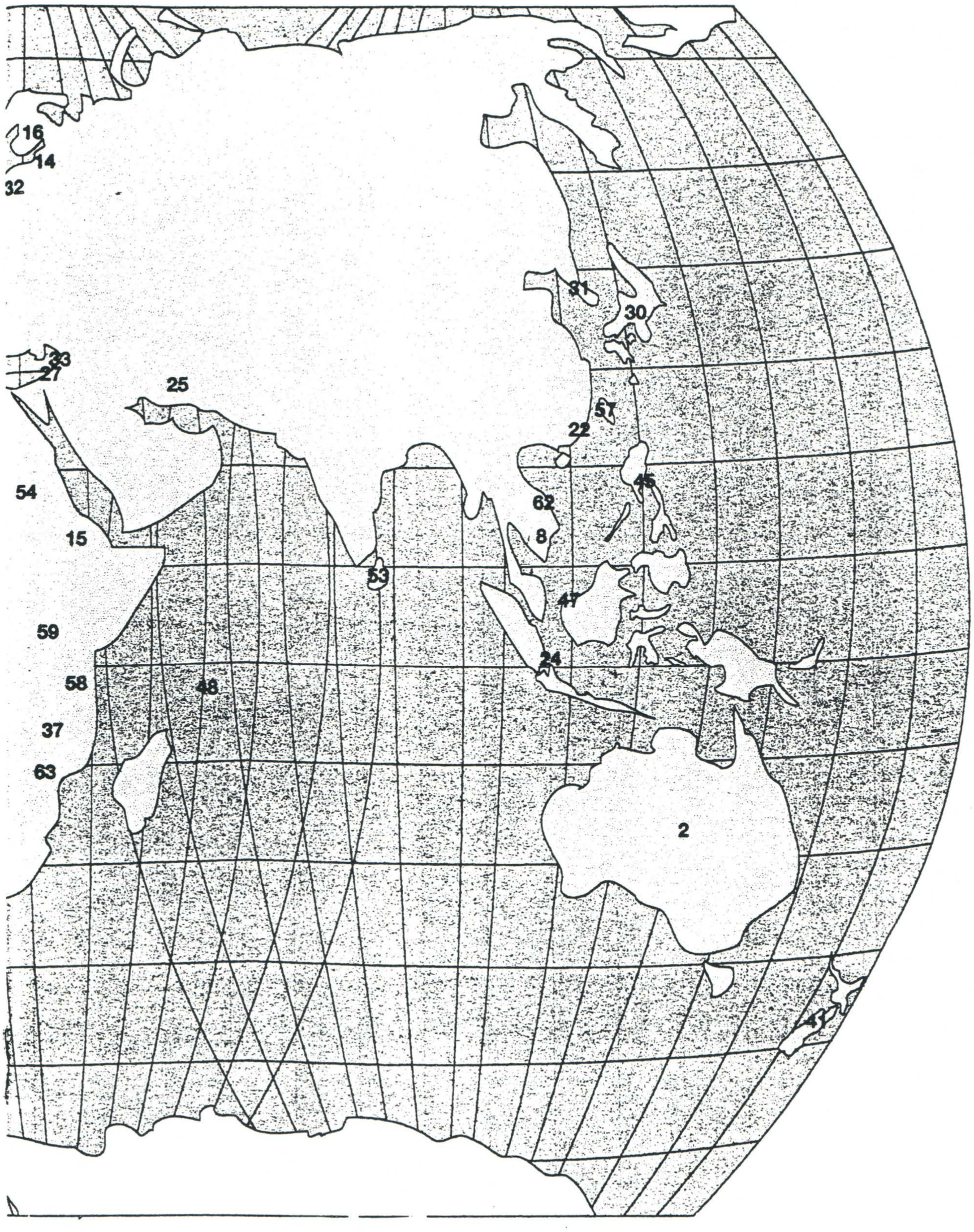
Papers available from UNICEF, Nutrition Section, 633 Third Avenue, TA-24A, Room 2436, New York, NY 10017, USA.
Tel: 1-212-824 6372 • Fax: 1-212-824 6465 • Website: http://www.unicef.org
The World Alliance for Breastfeeding Action (WABA), is a global network of organisations and individuals. WABA believes breastfeeding to be the right of all children and mothers; dedicates itself to protect, promote and support this right; and acts on the Innocenti Declaration. WABA works in close liason with UNICEF. WABA, PO Box 1200, 10850 Penang, Malaysia
Tel: 60-4-6584 816 • Fax: 60-4-6572 655 • Email: secr@waba.po.my • Website: http://www.origem.com.br/waba

World map showing countries where mi



1. Argentina
2. Australia
3. Austria
4. Belgium
5. Benin
6. Brazil
7. Burkina Faso
8. Cambodia
9. Canada
10. Chile
11. Czech Republic
12. Denmark
13. Ecuador
14. Estonia
15. Ethiopia
16. Finland
17. France
18. Gambia
19. Germany
20. Ghana
21. Greece
22. Hong Kong
23. Iceland
24. Indonesia
25. Iran
26. Ireland
27. Israel
28. Italy
29. Jamaica
30. Japan
31. Korea
32. Latvia

dwives are in membership with the ICM



33. Lebanon
34. Liberia
35. Libya
36. Luxembourg
29. Jamaica
30. Japan
31. Korea
32. Latvia

37. Malawi
38. Malta
39. Morocco
40. Netherlands
41. New Zealand
42. Nigeria
43. Norway
44. Paraguay
45. Philippines
46. Poland
47. Sarawak
48. Seychelles
49. Sierra Leone
50. Slovenia
51. Southern Africa
52. Spain
53. Sri Lanka
54. Sudan
55. Sweden
56. Switzerland
57. Taiwan
58. Tanzania
59. Uganda
60. United Kingdom
61. United States
62. Vietnam
63. Zimbabwe

Breastfeeding:

Education for life

Breastfeeding provides substances that are nutritionally perfect for human babies and protects them from illness. These are the elements needed for the growth and development of the infant's rapidly growing brain and central nervous system. It also provides the loving interaction that is the basis for the establishment of children's personalities and learning readiness. Breastmilk is the foundation of food security for all the babies of the world and is one of the world's most valuable, renewal natural resource. It is produced by women everywhere and indeed is the only food equally available to rich and poor alike.

In the field of education, there is widespread interest in improving educational content and in educational reform, yet the importance of breastfeeding and breastmilk are rarely taught at any level. Educators are usually not even conscious of this omission.

1-7 August 1999

WORLD BREASTFEEDING WEEK

In this year's World Breastfeeding Week, WABA aims to increase awareness in every country and at every level of the significance of breastfeeding and in particular to the development of the child. WABA believes that this very important topic of infant nutrition and care with a focus on integrating knowledge and skills that support breastfeeding into the instructional process deserves attention in all formal and informal educational settings.

Goals

- Increase public awareness of breastfeeding as the standard for infant development and growth.
- Encourage the incorporation of education on breastfeeding and appropriate infant feeding practices into all levels of formal and informal education.
- Work on relevant curriculum design with all types of educators and trainers from professional institutions, medical and other teaching schools, health organisations, public and private schools and hospitals, and community education centers.
- Involve students from pre-school up to teenagers in WBW 1999 activities and provide tools for popular education appropriate for different age groups.
- Encourage the integration of breastfeeding experiences and practices into children's developmental materials and toys.

Start organising now!

- Link with national and/or local educational authorities and discuss ways to integrate breastfeeding in the curriculum of primary and secondary schools.
- Involve teachers and other educators in discussions on breastfeeding and education, and how to organise for WBW 99. Set up *Educators for Breastfeeding* groups.
- Select school books and materials that can readily incorporate breastfeeding information and stories.
- List all medical, nursing and related health education schools and send them information on breastfeeding education. Follow-up with those who show an interest.
- Organise art and writing competitions for primary and secondary schools on various breastfeeding themes.

SPONSORSHIP

WABA does not accept sponsorship of any kind from companies producing breastmilk substitutes, related equipment and complementary foods. WABA encourages all participants of World Breastfeeding Week to respect and follow this ethical stance.

ABOUT WABA

WABA is a global network of organisations and individuals who believe breastfeeding is the right of all children and mothers and who devote themselves to protect, promote and support that right. WABA acts to help implement the Innocenti Declaration and works in close liaison with UNICEF. This WBW '99 calendar is sponsored by UNICEF.

WABA, PO Box 1200
10850 Penang, Malaysia
Tel: 604-658 4816
Fax: 604-657 2655
Email: secr@waba.po.my
www.elogica.com.br/waba

WBW Coordinating and Distributing Centres

ASIA

- WABA Secretariat
  WABA, PO Box 1200, 10850 Penang, Malaysia
  Tel: 604-658 4816
  Fax: 604-657 2655
  Email: secr@waba.po.my

South Asia

- BPNI, PO Box 10551, BP-33, Pitampura,
  Delhi 110 034, India
  Fax: 91-11-721 9606
  Email: ritarun@giasdl01.vsnl.net.in

AFRICA

- IBFAN Africa, PO Box 781, Mbabane, Swaziland
  Fax: 268-40546
  Email: 100100.3270@compuserve.com

- IBFAN Afrique Francophone
  01 BP 1776, Ouagadougou 01, Burkina Faso
  Fax: 226-303 888
  Email: ibfanfan@fasonet.bf

- MAPBIN/ICP
  PO Box 1134, Port Louis, Mauritius
  Fax: 230-211 4436

EUROPE

- BMAC
  23 St Andrew's Street, Cambridge CB2 3AX, UK
  Fax: 44-1223-464417
  Email: babymilkacti@gn.apc.org

- GIFA
  CP 157, CH-1211 Geneva 19, Switzerland
  Fax: 41-22-798 4443
  Email: philipec@iprolink.ch

- AFS
  SandstraBe 25, 97199 Ochsenfurt, Germany
  Fax: 49-9331-20585
  Email: afs.benkert@t-online.de

- WBW International Coordinator
  Denise Arcoverde, Av. Beira Mar, 3661 Loja 18
  Casa Caiada, Olinda, PE 53130-540, Brazil
  Fax: 55-81-432 7701
  Email: origem@elogica.com.br

LATIN AMERICA

- IBFAN Latin America
  Conaplam, 23 Calle 26 - 60, zona 5
  Guatemala City, Guatemala
  Fax: 502-335 3711
  Email: ruth.arango@starnet.net.gt

- Cefemina
  Apartado 5355, 1000 San Jose, Costa Rica
  Fax: 506-224 3986
  Email: cefemina@sol.racsa.co.cr

- CEPREN, Av Pardo 1335, Of 302, Lima 18, Peru
  Fax: 51-1-241 6205
  Email: cepren@amauta.rcp.net.pe

Brazil & Lusophone countries

- Origem group/WABA Brazil
  (see address WBW intl. coordinator above)

NORTH AMERICA

- NABA
  254 Conant Road,Weston, MA 02493-1756, USA
  Fax: 1-781-893 8608
  Email: marshalact@aol.com

- LLL International
  1400 N Meacham Road,Schaumburg
  IL 60173-4840, USA
  Fax: 1-847-519 0035
  Email: lllhq@llli.org

PACIFIC

- NMAA
  PO Box 4000, Glen Iris, VIC 3146, Australia
  Fax: 61-3-9885 0866
  Email: nursingm@vicnet.net.au

- Secretary PINDA
  c/o Community Nutrition, School of Agriculture,
  USP, Alafua Campus, Private Mail Bag, Apia,
  Western Samoa
  Fax: 685-22933
  Email: sio_b@samoa.net

NEWFOUNDLAND and LABRADOR MIDWIVES ASSOCIATION
APPLICATION FOR MEMBERSHIP
1999

Name: _____
(Print) (Surname) (First Name)

All Qualifications: _____

Full Address: _____

_____

Postal code: _____ Telephone No. _____
(home)

Telephone No. _____ Fax No. _____
(work)

E-mail Address: _____

Work Address: _____

_____

Area where working: _____

Retired: _____ Student: _____ Unemployed: _____

List of Organizations of which you are a member (the Association receives requests from various organizations for representatives to review articles, attend conferences, be on committees). Your name would not be forwarded without your consent.

Provincial: _____

National:_____

International: _____

I wish to be a member of the Midwives Association and I enclose a cheque/money order from the post office for: $_____
(Cheques/money orders only (no cash) made payable to the Newfoundland and Labrador Midwives Association).

Full membership for midwives is **$35.00** (as this includes the Canadian Confederation of Midwives fees which the Association has to pay).
Associate membership for those who are not midwives is **$20.00**
Membership for those who are unemployed/retired is **$10.00**
Membership for those who are residing outside of Canada **$45.00** (to cover the cost of the extra postage).

Signed: _____ Date: _____

Return to: Pamela Browne, P.O. Box 112, Station A, Goose Bay, Labrador A0P 1S0